WYOMING WORKERS' SAFETY AND
COMPENSATION DIVISION

CHIROPRACTIC UTILIZATION GUIDELINES FOR THE CARE AND TREATMENT OF INJURED WORKERS

IN CONSULTATION WITH THE CHIROPRACTIC ADVISORY PANEL
DEPARTMENT OF EMPLOYMENT
STATE OF WYOMING

AUGUST 2005

Chiropractic Introduction

Mission of Intent

To ensure professionally appropriate chiropractic care within the scope of practice while adhering to the Wyoming Worker's Safety and Compensation rules and regulations. It is the intent of the Chiropractic Advisory Panel to ensure professional case management and to organize an equitable review process that serves the injured worker, the Doctor of Chiropractic, and the State of Wyoming.

History

The Chiropractic Advisory Panel was formed in 1992 to serve the Chiropractic profession in Wyoming by offering a review process for claims and issues arising out of care, treatment, and issues relative to the injured workers.

The formation of guidelines and protocols is intended to help clarify and govern the review and payment of chiropractic claims.

Authority

Doctors of Chiropractic may elect to provide care for injured Wyoming workers. Those providers who elect to serve patients within the Wyoming Worker's Safety and Compensation system also accept the responsibility of practicing in a manner consistent with these guidelines. Once it has been determined that the injured worker will benefit from treatment provided by a chiropractor, certain established, ethical guidelines should be followed. The Division should only be billed for procedures, which were provided and are reasonable and medically necessary to treat the injured worker's compensable injury. Appropriate documentation should always be provided. Once the injured worker has recovered from the injury or reached a level of ascertainable loss, he or she should be released from care and a final billing should be sent to the Division. Any further treatment may be the injured worker's responsibility.

The authority of these guidelines is derived from the *Wyoming Workers' Safety* and *Compensation Rules, Regulations and Fee Schedules,* **Chapter 8, Section, 1,** which states; **…The Division adopts…Chiropractic Utilization Guidelines for the Care and Treatment of Injured Workers, which will be used in its evaluation and payment of …chiropractic claims…**

Maximum Therapeutic Benefit

Injured workers who have undergone a course of care and are considered to be at a point of maximum therapeutic benefit should be discharged from care. Preventative or maintenance care will not be eligible for compensation. Any change in a patient's condition believed to be associated with a prior worker's compensation claim requires comprehensive documentation to support and validate relatedness and return to care. The responsibility of the provider is to assist the patient in reaching pre-injury status or to determine maximum therapeutic benefit and discharge from care.

Permanent Impairment and Ongoing Symptoms

Injured workers who have reached maximum medical improvement with an ascertainable loss, but have been awarded a permanent impairment rating based on ongoing symptoms, may be eligible for consideration for supportive care following Division guidelines.

Fee Schedule

All bills and fees submitted for payment will be reviewed and audited for relatedness, appropriateness and reasonableness in accordance with the adopted Workers' **Wyoming Safety and Compensation Rules and Regulations and Fee Schedules. Wyoming Statute Section 27-14-101(b) and 27-14-802(a).**

Wyoming Workers' Compensation must be billed the same as the general public for the same or similar service(s).

Reimbursement and Exceptions

All codes and unit values will be reimbursed according to the Fee Schedule unless otherwise established by the Chiropractic Advisory Panel.

Billing Guidelines

Refer to the Division's Billing Guidelines available under separate cover from:

State of Wyoming
Department of Employment
Workers' Safety and Compensation Division
P.O. Box 20070
Cheyenne, WY 82003-7001

Call 307-777-5954 for assistance with coding or billing issues. Ask for the Chiropractic Bill Review Nurse.

FORMAT

SECTION 1

The quality of health care is dependant on the ability to gather, organize, analyze and make decisions on clinical data. Good decisions are the result of accurate and complete facts being retrievable from a patient's records. Incomplete, illegible, or ill-prepared records will stop the review process and ultimately prevent the doctor from receiving a timely compensation. Templated forms, "canned notes", computer generated notes, and fill-in-the-blank type documentation are not professionally adequate. Notes lacking patient specific information are not relevant and will not be accepted.
Each office visit represents a new and separate chapter in the medical/legal records of the case. As such, the records must accurately reflect the current status of each patient, the treatment goals, and future treatment recommendations.

I. INITIAL EVALUATION

A thorough case history should include:

a. Treating diagnosis
b. Work injury history
c. Past medical history
d. Specific body part injured and present health pattern
e. Treatment goals and expected time of treatment
f. Factors of disability

II. DAILY PROGRESS NOTES

Submitted documentation should include:

a. SOAP note format
b. Specific body part treated
c. Progress statement
d. Documentation of non-compliance

i. Soap Note Format/Style of Construction

1. Subjective complaints: The patient's complaints should be recorded at each visit (in the patient's own words when possible) indicating improvement, worsening or no change.
2. Objective findings: Changes in the clinical signs of a condition should be noted at each visit in the doctor's own words.
3. Assessment or diagnosis: It is not necessary to update this category at each visit. However, periodic clinical re-evaluations should be performed and these results included in the daily entries with any alteration in the diagnosis.
4. Plan/Procedure: A provisional plan of management should be made as this plan is modified and/or as a patient enters a new phase of treatment. Changes should be noted. Daily recording of procedures performed should include descriptions of manipulations performed, soft tissue techniques, modalities used with documentation to include area of

treatment, duration and who performed modality, exercises prescribed, or prescribed diet and activity instructions.

ii. Written Reports

1. History
   a. Presenting complaints.
   b. Past health history.
   c. Family history.
   d. Personal and/or social history.
2. Examination Findings
   a. Documented examination and diagnostic procedure(s) findings.
3. Assessment, diagnosis or clinical impression
   a. Documented diagnosis or clinical impression.
   b. Documented subsequent evaluation and/or procedures.
   c. Documented prognoses.
   d. Documented appropriate referrals if needed.
4. Plan of management and/or responses to treatment
   a. Initiate an efficient and effective treatment plan.
   b. Use appropriate treatment consistent with fair appraisal of the cost/benefit ratio.
   c. Document contradictions or specific considerations for care and modifications needed in continued care and/or referrals.
   d. Recorded treatment in a SOAP format
5. Prognosis and/or outcome expectations
   a. Assess the effectiveness of the treatment plan and make appropriate changes as needed.
   b. Perform ongoing assessment using the SOAP format.
   c. Document extent of re-examination necessary to assess significant exacerbations or deviation from planned recovery.
6. Ancillary documents
   a. Correspondence (sent and received).
   b. Specialty report (diagnostic imaging, lab, nerve conduction studies, etc.)
   c. Communications (telephone conversations, dialogue with family or friends of the patient, etc.)
7. Discharge
   a. Injured workers who have undergone a course of care and are considered to be at a point of maximum therapeutic benefit should be discharged from care.
   b. Non-compliance with and/or non-attendance of established treatment protocols and physician recommendations increase expenses to the Division and prolongs rehabilitation, often leading to unsatisfactory outcomes and delayed recovery. Tracking of compliance is intended to facilitate the injured worker's optimal recovery. When an injured worker has unexcused absences and/or canceled appointments approaching 20% of the time, or if a pattern of cancellations develops

which indicated non-compliance, i.e. hunting trips, long vacations or consistent 3 or 4 day weekends, and it impacts their rate of recovery, it should be reported by the doctor to the claims analyst. The Division places great emphasis and importance on compliance with attendance of prescribed medical and therapeutic treatments as established by the doctors. The Wyoming Workers' Compensation Act (Wyoming Statute 27-14-404 (h)) states: Payment under subsection (a) of this section shall be suspended if the injured employee fails to appear at an appointment with his health care provider. Payment shall be suspended under this subsection until such time as the employee appears at a subsequent rescheduled appointment. Payment shall not be suspended for failing to appear at an appointment if the employee notifies the case manager or the division prior to the appointment or within twenty-four (24) hours after missing the appointment and the division determines, after recommendation by the case manager, that the employee made reasonable efforts to appear at the appointment. At the time of the first benefit payment under this section, the division shall notify the employee of the requirements and other provisions of this subsection, including the procedures to be followed in notifying the case manager or the division. For purposes of this subsection, health care provider includes physical and occupational therapists.

CODING PROCEDURES

SECTION 2

The following is used as general treatment parameters in evaluating chiropractic treatment. Any time treatment goes beyond these parameters, written justification must be provided documenting the necessity.

Modalities/Procedure documentation must include the region applied.

Billing Time-Based Codes
Billing time-based codes requires documentation in the patient record to include the time involved.

CODE 97010
Application of a modality to one or more areas; hot or cold packs
If superficial heat is provided simultaneous through the predominant modality (i.e., traction tables, hydro tables, mechanical massage tables, whirlpool, etc.) no additional charge shall be made for hot packs (97010). The simultaneous application of superficial heat through a predominant modality, to the same region, during the same period of time, does not add value to the basic service performed.

CODE 97012
Application of a modality to one or more areas; traction, mechanical
Documentation must state "mechanical" traction. Flexion/distraction, Intersegmental Distraction, Cox, Leander, manual traction, are considered techniques that would be inclusive in the manipulative codes (98940, 98941, 98942).
In office mechanical traction will be considered a duplication of service and will not be reimbursed when the patient is performing home traction to the same treatment area.
Vertebral axial decompression will be paid as traction.

CODE 97014
Application of a modality to one or more areas; electrical stimulation (unattended)
If electrical stimulation and ultrasound are provided through the same transducer, no additional charge shall be made for electrical stimulation. The simultaneous application of ultrasound and electrical stimulation through the same transducer, to the same region, during the same period of time, does not add value to the basic service performed. *CPT codes should be viewed as descriptors of service only, not billable items in their own right. The fact that a CPT code exists for electrical stimulation does not add value to the basic service performed.*
Only one 97014 will be paid on the same date of service if the compensable areas are in close proximity.

CODE 97024
Application of a modality to one or more areas; diathermy
The use of diathermy and ultrasound on the same treatment area on the same visit will be considered a duplication of service as they both provide heat. Consideration will be given to one but not both therapies.
Documentation must include the area of application.

CODE 97032
Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
If electrical stimulation and ultrasound are provided through the same transducer, no additional charge shall be made for electrical stimulation. The simultaneous application of ultrasound and electrical stimulation through the same transducer, to the same region, during the same period of time, does not add value to the basic service performed. *CPT codes should be viewed as descriptors of service only, not billable items in their own right. The fact that a CPT code exists for electrical stimulation does not add value to the basic service provided. If billed documentation must include the areas of application.*
Only one 97032 will be paid if compensable areas are in close proximity.

CODE 97035
Ultrasound, each 15 minutes
The use of ultrasound and diathermy on the same treatment area on the same visit will be considered a duplication of service as they both provide deep heat. Consideration will be given to one but not both therapies.
If electrical stimulation and ultrasound are provided through the same transducer, no additional charge shall be paid for electrical stimulation. The simultaneous application of ultrasound and electrical stimulation through the same transducer, to the same region, during the same period of time, does not add value to the basic service performed. *CPT codes should be viewed as descriptors of service only, not billable items in their own right. The fact that a CPT code exists for electrical stimulation does not add value to the basic service provided.* Documentation must include the area of application.
Only one 97035 will be paid on the same date of service when compensable areas are in close proximity.

CODE 97110
Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
See Rehab Guidelines

CODE 97112
Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception
See Rehab Guidelines

CODE 97124

Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and / or tapotement (stroking, compression, percussion)

This is a soft tissue procedure performed on one-to-one direct patient contact. Only a doctor, or massage therapist under the doctor's direct supervision and in conjunction with an active chiropractic treatment program, can be compensated for this. Documentation must note the person providing this service or the bill will be returned to the vendor for clarification. Massage, including effleurage, petrissage, and / or tapotement (stroking, compression, percussion) will be considered for reimbursement when performed to the same region as CMT with appropriate documentation (i.e. myofascial release, trigger point therapy, myelotherapy, soft tissue mobilization, massage). The documentation must be co-signed by the supervising physician. Reimbursement for massage will only be made for massage applied to the area(s) of the original compensable injury.

CODE 97139

Unlisted procedure, modality or supply code (i.e. 97139, 97039, 99070)

If no specific procedure code is available fitting the description of the procedure performed and an unlisted procedure code must be used, include the narrative description on item 19 of the HCFA 1500 form, if a coherent description can be provided within the confines of that box. If not, an attachment must be submitted with the claim. The unlisted procedure must be supported by documentation in the patient's record.

CODE 97140

Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes

This code is mutually exclusive, redundant, and considered a duplicate service when performed to the **same compensable region** as **CMT (98940, 98941, 98942, 98943).** The 97140 code encompasses a range of manual techniques, including, but not limited to, joint mobilization / manipulation, manual lymphatic drainage, manual traction, and manual soft tissue mobilization. Since this code can include manipulation services, use of the code in the **same region** as a CMT service on the same encounter would not be appropriate and will not be considered for reimbursement. If CMT and Manual Therapy (97140) are provided to **separate compensable body regions**, the codes will not be considered as a duplicate service. A "59" modifier should be added to the 97140 code to indicate a separate procedure.

Code 97140 is mutually exclusive, redundant, and considered a duplicate service when performed to the **same compensable region** as **massage therapy (97124).** The 97140 code encompasses a range of manual techniques, including, but not limited to, joint mobilization / manipulation, manual lymphatic drainage, manual traction, and manual soft tissue mobilization. Since this code can include massage services, use of this code in the **same compensable region** as a massage code on the same encounter would not be appropriate and will not be considered for reimbursement. If massage and manual therapy are provided to **separate compensable body regions**, the code will not be considered as a duplicate service. A "59" modifier should be added to the 97140 code to indicate separate procedure.

CODE 97504
Orthotics fitting and training, upper and / or lower extremities, each 15 min
Orthotics will be judged on an individual case basis.

CODE 97530
Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
See Rehab guidelines

CODE 97535
Self care / home management training, "direct one on one contact by provider, each 15 minutes"
The Division will pay up to four teaching/monitoring sessions for up to two units per session maximum per case. The documentation must demonstrate medical necessity and goals.

CODE 97545
Work hardening / conditioning; initial 2 hours
Work hardening is a comprehensive program including education, reconditioning and specific work simulation with respect to task, quality, quantity and intensity.
Work hardening programs entail a progressive increase in the number of hours per day that a patient completes work simulation tasks until the patient can tolerate a full workday.
Work hardening programs should meet criteria consistent with that established by the Commission for the Accreditation of Rehabilitation Facilities (CARF) to assure such programs meet certain standards involving program design and efficacy.
Work hardening must be performed at an appropriate rehabilitation facility.

CODE 98940
Chiropractic manipulative treatment (CMT); spinal, one to two regions

CODE 98941
Chiropractic manipulative treatment; spinal, three to four regions

CODE 98942
Chiropractic manipulative treatment; spinal, five regions

CODE 98943
Chiropractic manipulative treatment; extra spinal, one or more regions
This code can be used by itself or in conjunction with a spinal CMT code. When used on the same day as another CMT code, the extra spinal code should have a "51" modifier and will be paid at 50% reduction.

CODE 99050
Services requested after posted office hours in addition to basic service, and
CODE 99054
Services requested on Sundays and Holidays in addition to basic service
Documentation must describe special circumstances under which extraordinarily unusual weekend or holiday appointments were medically necessary. These codes are intended to be reported for practices whose usual posted hours do not ordinarily included weekends or holidays.

CODE 99070
Supplies and material (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided. An invoice and supportive documentation must be supplied with the billing.

CODE 99071
Educational supplies, such as books, tapes, and pamphlets, provided by the physician for the patient's education at cost to physician. An invoice and supportive documentation must be supplied with the billing.

CODE 99201
Office or other outpatient visits for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision-making. Counseling and / or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and / or family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and / or family.

CODE 99202
Office or other outpatient visits for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination, and straightforward medical decision-making. Counseling and / or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and / or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and / or family.

CODE 99211
Office or other outpatient visits for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

CODE 99212
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components; a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and / or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and / or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and / or family.

CODE 64550
Application of surface (transcutaneous) neurostimulator
To be paid x 1 only

CODE 72010
Radiologic examination, spine, entire, survey study, anteroposterior and lateral

CODE 72020
Radiologic examination, spine, single view, specify level
This is a component of the scout survey of the lumbar spine and not to be billed separately.
If billed 72020 and 72040 on the same date of service, the 72020 will be denied as it is usual and customary practice to include the AP open mouth within the 72040 x-ray code.

CODE 72040
Radiologic examination, spine, cervical; two or three views

CODE 72050
Radiologic examination spine, cervical; minimum of four views

CODE 72070
Radiologic examination, spine; thoracic, two views

CODE 72100
Radiologic examination, spine; lumbosacral; two or three views
If billed 72020 and 72100 only 72100 will be paid. St. Anthony's RVS states that this code reflects two or three views which would incorporate the L5-S1 spot, also known as "conedown".

CODE 72110
Radiologic examination, spine; lumbosacral; minimum of four views

**** IF BILLED 72040, 72070 AND 72100 THE CODES WILL BE COMBINED AND PAID AS CODE 72010 ONLY.***

SUPERVISED REHABILITATIVE PROGRAMS

SECTION 3

Supervised Rehabilitative Programs
Supervised reconditioning / therapeutic exercise will only be considered for those patients with documented physical deficit and who have not demonstrated objective carry over and benefit from an assigned home exercise program. A quantifiable base line should be individually assessed, and a treatment plan tailored to meet their individual goals. Functional gains should be objectively measured. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. A treatment plan request must be submitted to the Division prior to initiation of a supervised rehabilitative program. The practitioner must delineate the quantifiable functional deficit, treatment goals, and a realistic endpoint of care.
Implementation of a supervised reconditioning / therapeutic exercise program must be considered with sound clinical judgment, reasonableness, and in consideration of medical necessity. When performing spinal rehabilitation current epidemiological literature on the natural history of spinal soft tissue injuries indicates that nearly 90% will resolve spontaneously within 90 days regardless of the type of intervention (including none). Only 10-15% of patients who sustain an acute spinal injury may require a supervised program.

Reconditioning / Therapeutic Exercise when Combined with Passive Modality Treatments
In general, passive modalities and active supervised reconditioning exercise separate phases of treatment for patients suffering form spinal disorders. Passive modalities that include ultrasound, diathermy, electrical stimulation, massage, hot or cold packs, etc., when combined with reconditioning exercise, adds an additional layer of medical cost without any proven corresponding improvement in therapeutic outcome. Withstanding acute exacerbations the practice of combining (i.e. billing for) passive modality treatment in conjunction with supervised reconditioning exercise program will not be approved. If a significant exacerbation occurs, it must be well documented and a brief plan of acute care should be defined to include end points in care with a return to pre-exacerbation status.

Supervised Reconditioning / Therapeutic Exercise Code Cap
The Division may pay up to four units (l unit = 15 minutes) per day of any (one code or combination) of one-on-one exercise code as listed.

97110 Therapeutic exercise
97112 Neuromuscular re-education
97116 Gait training
97530 Therapeutic activity

The application of these codes require direct (one-on-one) patient contact by the Chiropractor. *<u>These codes can only be billed after failure of an assigned home exercise program. (See code 97535</u>)

Coding / Billing Procedures

Each CPT code billed should represent a separate and distinct clinical procedure. Each CPT code utilized and its associated rehabilitative procedure should be clearly identified and well documented. Procedures such as brief cardiovascular warm up / cool down stretching exercising, etc. is considered components of other predominant procedures and should not be billed separately.

CPT codes should be viewed as descriptors of service only, not billable items in their own right. Generally, CPT codes related to supervised reconditioning / therapeutic exercise are time based, billed in 15 minute increments. For coding purposes it is irrelevant whether 1,2, 3, …., 10 different procedures are performed during a given patient encounter. Total time spent remains the key factor when billing. Total time must be documented in the chart notes.

Self Care Home Management

The Chiropractic practitioner is involved in evaluating and minimizing the effects of disabling conditions of those being served.

The Chiropractic treatment philosophy is involved in a process of maximizing the individual's functioning within the Chiropractic office and outside the practioner's office.

The Chiropractor desires to achieve an integrated understanding concerning the screening, programming and implementation of aerobic and postural therapeutic exercise program.

The programming of patients should be based upon sound clinical judgment built upon the needs of the individual following established protocols.

TREATMENT PARAMETERS

SECTION 4

The Chiropractor shall prepare a diagnosis-based treatment plan, which includes specific treatment goals with expected time frames for completion. The Chiropractic Panel shall adopt the most current addition of Procedural Utilization Facts, Chiropractic Care Standards, A Reference Guide for determination of optimal recovery guidelines.

1. **Healing Times**
   Most authorities expect healing times for strain/sprains to be from 4 to 12 weeks, depending on severity. It is expected that the soft tissue injury associated with a subluxation complex should fall in the same parameters. If care is needed beyond this period, other health care options should be considered.

2. **Initial Phase**
   Consecutive daily services may constitute accepted clinical practice for selected conditions with supportive documentation. Reimbursement for consecutive daily care would be considered for up to ten days total at the beginning of the case.

   Consecutive days include weekends and holidays

   Usage of more than one care session per day may constitute accepted clinical practice for selected conditions with supporting documentation. Reimbursement would be considered for two treatment sessions a day for up to three consecutive days at the beginning of the case.

3. **Mid-Phase**
   Treatment needs usually decrease with patient progress. We expect to see one to two modalities or procedures in addition to manipulation with the initiation of exercise if appropriate.

   If therapy does not produce the desired effect within thirty days, continued care would not be clinically indicated. Compensation for care after the thirty days will be reviewed or denied.

4. **Final Phase**
   Treatment needs usually decrease with patient progress. We expect to see zero to one modalities or procedures in addition to manipulation. The claimant should have reached pre-injury status or ascertainable loss at this time and should be discharged from active chiropractic care.

   The provider is required to identify all therapy modalities or procedures administered to the patient. If a given treatment or modality is not producing positive results within 3 to 4 weeks, the treatment should be either be modified or discontinued.

5. Supportive Care

Long-term treatment/care that is therapeutically necessary. This is treatment for patients who have reached maximum therapeutic benefit, but who fail to sustain benefit and progressively deteriorate when there are periodic trials of treatment withdrawal. Supportive care follows appropriate application of active and passive care including rehabilitation and/or lifestyle modifications. Supportive care is appropriate when alternative care options, including home-based self-care or referral have been considered and/or attempted. Supportive care may be inappropriate when it interferes with other appropriate primary care, or when risk of supportive care outweighs its benefit, i.e. physician/treatment dependence, somatization, illness behavior or secondary gain. 1,2,3,4.

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2. Chapman-Smith D. Long-Term Care-Justification and Reimbursement. *The Chiropractic Report*. Jan 1994; 8(1); 2.
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The need for supportive care must be established through appropriate documentation and will be determined on a case by case basis. Supportive care will only be considered for those workers who have sustained an ascertainable loss and have received an impairment rating. Most chronic cases that require supportive care are characterized by multiple complicating factors. These factors should be carefully identified and documented in the worker's file to support the categorization of a condition as chronic, complicated, and unstable. The need for supportive care must be reestablished every six months.

A worker may be eligible to receive chiropractic and/or medical therapeutic care when ongoing pain or dysfunction exceeds the injured worker's ability to self-manage the original compensable injury. This periodic delivery of "supportive care" should assist the patient in preventing further deterioration of their injury state. A significant exacerbation should be well documented and a brief plan of acute care should be defined to include end points in care with a return to pre-exacerbation status. The worker would then be released to self-management strategies.

Care must be based on therapeutic need with an increasing shift in emphasis from passive to active self-care and independence. The repeated use of the same passive care measures alone generally presents an increased probability of chronicity, physician dependence, and over-utilization. Pain is not in and of itself

an indication for continued care. Continued care is rarely reasonable and necessary if there is no objective benefit.

Documentation must demonstrate repeated attempts over time to withdraw the worker from passive care and that alternative care options have been attempted such as:

- Activity-of-daily-living (ADL) recommendations/counseling
- Ergonomic recommendations/counseling
- Exercise recommendations/counseling and instruction
- Home care recommendations
- Lifestyle modifications/counseling
- Multi-discipline approaches
- Pain management recommendations
- Psycho-Social counseling
- Risk avoidance counseling
- Referral to Vocational Rehabilitation

6. Maintenance / Preventive Care

Maintenance or preventive care is treatment for patients who have no present pain or symptoms but seek to prevent pain or disability, promote health and enhance the quality of life. This type of care is not therapeutically necessary, is considered elective, and will not be compensated.

GENERAL GUIDELINES

SECTION 5

1. On all claims where there is indication of extended treatment, a supplemental information form (S.I.F.) may be required. This will enable review and effective monitoring of the file before delayed or denied payment becomes necessary. The S.I.F. will be sent to the provider by the Division. Failure to complete and return the S.I.F. will result in denial of payment until the S.I.F. is returned and reviewed by the Chiropractic Advisor.

2. The Division will consider payment for an initial and discharge examination.

3. Usually there is no medical necessity to perform re-examination on patients that are meeting or exceeding their treatment goals, however, the Division will consider payment for re-examinations to assess significant exacerbations or deviations from planned recovery *(Re-examinations would likely initiate changes in the treatment plan, including possible referral)*

4. In the event of an exacerbation or re-injury, the attending physician must document said incident according to date, etiology, updated subjective and objective findings, updated diagnosis and prognosis and treatment plan. *(Documentation must support a re-injury resultant from a significant event or trauma).*

5. Chart notes and supportive documentation must be attached to each billing. All ICD-9 diagnosis codes and CPT treatment and procedural codes must be validated in the patient chart and coordinated as to the diagnoses and treatment code descriptors. All records must be legible and understandable. Uniform chiropractic language should be used within the profession for describing care and treatment. Non-standard abbreviations and indexes should be defined.

6. Complete, appropriate, orderly and timely billing is required to provide a timely and correct payment.

7. The nationally accepted CMS (formerly known as HCFA) billing 1500 form must be completed in detail. This means all required fields must be completed. Patient's name, social security number, address, date of birth, sex, county where injury occurred, case number, date of injury, employer's name, ICD-9 code, itemized CPT codes, total charges, chiropractor's name, address, and the date claim was filed. Completed claims are submitted to: Wyoming Workers' Safety and Compensation Division, P.O. Box 20070, Cheyenne, WY 82003-7001

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